

## NEW PATIENT REGISTRATION & RELEASE OF INFORMATION AUTHORITY

## **Patient Details** Name: Date of Birth: Address: Phone Nos: Home: ...... Mobile: ..... Would you like to receive a reminder via text message for future appointments? (Please tick 1): \* Yes \*No Emergency Contact: ..... Emergency Contact Ph No: ..... **Practitioners Details** Referring Practitioner: Your G.P.: Dr.....Surgery Address **Medical History** Allergies: ...... Past/Present Medical Problems (Please tick []): Diabetes \* Heart Disease \* Asthma \* Hypertension \* Hepatitis \* Other (Please specify): ..... Past/Present Eye Problems (Please tick 1): \* Cataract Glaucoma \* Squint Surgery Eye Injury \* Other Eye Surgery (Please specify): ...... Current Medications: ..... Current Eye Drops: ..... I consent to the use of my personal health information by Gympie Eye Centre and the disclosure of my personal health information to other health professionals to assist with my continuing care.